MassHealth

Third Party Liability Indicator

Date: _____

Head of Household: _____ SSN: _____ Telephone No.: (____) _____
(Last, First, MI)

(If you need more space to finish any section on this form, please use the back of this form.)

1. Medicare Information

Name: _____ Claim No.: _____
(Last, First, MI)

Part A Start Date: _____ Part A End Date: _____

Part B Start Date: _____ Part B End Date: _____

2. Commercial Health Insurance Information

☐ New Policy ☐ Change Policy ☐ Terminate/Closed Policy ☐ Additional Policy ☐ Policy Ended Due to Leaving Job

Policyholder's Name: _____ Date of Birth: _____ SSN: _____ Policy No.: _____
(Last, First, MI)

Insurance Company Name: _____ Group No.: _____ Policy Start Date: _____ Policy End Date: _____

Insurance Address: _____ Insurance Telephone No.: (____) _____

Employer/Union Name: _____ Employer/Union Telephone No.: (____) _____

Family Members Covered:

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

3. Access to Employer-Sponsored Health Insurance

If not currently insured, does any family member's employer offer health insurance? ☐ Yes ☐ No

Employer/Union Name: _____ Employer/Union Telephone No.: (____) _____

Employer/Union Address: _____

Mail or fax this form to:
MassHealth
Third Party Liability Unit, P.O. Box 9212, Chelsea, MA 02150
Tel.: 1-888-628-7526 • Fax: 617-357-7604